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payments under Section 1.j. of this attachment, if it is believed that technical error has been made in thecalculation. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification under Section 1.j. of this attachment, and payment adjustment amounts, or a letter of notification that the hospital does not qualify for such payments. Such a request must include a clear explanation of the reason for the appeal and documentation that supports the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request or review.

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2. FEDERALLY QUALIFIED HEALTH CENTERS:

a. To be qualified as a Federally Qualified Health Center (FQHC), providers, clinics and centers must receive a grant under Section 329, 330 or 340 of the Public Health Service Act or be determined to meet the requirements for receiving such a grant by Health Resources and Services Administration.

i. Cost Reporting

The FQHC must submit a copy of financial statements audited by an independent Certified Public Accountant. HCFA Form 242 must be filed with the Department on or before December 31 of each year. The cost report must cover a full fiscal year ending on June 30 or other fiscal year which may be approved by the Department. Payments will be withheld from any provider which has not submitted the cost report as of January 1. These cost reports will be used to calculate a cost-based rate from reasonable and related costs that the Center will submit on a yearly basis. Such costs cannot exceed the reasonable costs as determined by the applicable Medicare cost reimbursement provisions set forth in 42 CFR Part 413.1.

ii. Payment Rate

A. Medical Encounter Rate

1. Payment for medical services rendered on or after April 1, 1990 shall be made at an individual, all-inclusive prospective per diem rate calculated on the basis of the Department's encounter rate methodology. The method for determining allowable direct cost factors is exactly the same as used for Medicare, employing the same allowability screens from the HCFA Form 242, with one exception. For Medicaid rates, the Direct Care Staff Physicians Section has been expanded to include other health care professionals, specifically, physician assistants, nurse practitioners, nurse midwives, podiatrists and clinical psychologists. Additionally, the Medicaid methodology considers supplemental costs associated with services not covered under Medicare: pharmacy, patient transportation, medical case management, health education and nutritional counseling.

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In calculating the rate, direct costs are divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff. This cost per direct staff encounter is then multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter. The cost per direct staff encounter and the allowable overhead cost per encounter are added together, then compared to the established HCFA ceiling on FFHC rates. The lesser of the two is used as the base medical encounter rate.

To determine the supplemental rate, the supplemental service cost which includes pharmacy, patient transportation, medical case management, health education and nutritional counseling costs is divided by the total number of direct staff encounters to determine the direct supplemental service cost per encounter. In addition, the supplemental overhead cost is multiplied by the allowable FQHC overhead rate factor. The supplemental cost per encounter for direct and overhead are added together, and this cost is compared to the 75th percentile of the statewide range of supplemental service costs per encounter. The lesser of the two is used as the supplemental medical encounter rate.

The base Medicaid encounter rate is added to the supplemental encounter rate. The sum of these two component rates is multiplied by the annual inflation factor to yield the total medical encounter rate.

2. The Department will annually calculate prospective rates to be effective each year on July 1. The reported allowable cost will be adjusted to the midpoint of the rate year, multiplied by an inflation factor calculated from the following indices published in the most recent available edition of the DRI/McGraw-Hill Health Care Costs: nursing and personal care, service workers, other professional fees, private transportation, nonrental space occupancy costs, rent, office costs and utilities.

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B. Dental Encounter Rate

Payment for dental services rendered on or after April 1, 1990 shall be made at an individual, all-inclusive prospective per diem rate calculated in a manner similar to the Department's medical encounter rate methodology.

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In calculating the rate, direct dental costs are divided by the number of dental encounters to determine an allowable cost per encounter delivered by direct staff. This cost is then multiplied by the allowable overhead rate factor to calculate the overhead cost per encounter. Both costs are added together, then compared to the 75th percentile of the statewide range of dental services and overhead costs per dental encounter. The lesser of the two will determine the dental encounter rate. The reported allowable cost will be adjusted to the rate year by an inflation factor described in 2.a.ii.A.2..

iii. Interim Rate

Until the individual provider cost-based rates are developed, an interim reimbursement for covered clinic services rendered shall be made at the higher of: 1) the provider's existing rate in effect on March 31, 1990 as established by the Department, 2) the provider's approved Medicare rate established by the designated Medicare intermediary for rural health centers or federally funded health center services, or 3) the 75th percentile of the statewide range of the Department's established encounter rates as of March 31, 1990.

Payment shall be made at the interim encounter rate to clinics enrolled before January 1, 1991 for covered clinic services rendered from either the date of enrollment or March 31, 1990 whichever is later, and the certified mail date of provider receipt of the cost-based rate established by the Department.

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This interim rate will be a one-time rate that will be paid from April 1, 1990 or the date of the provider enrollment until: 1) the provider completes HCFA Form 242 and receives its individual cost-based rate, or 2) December 31, 1990, whichever comes first.

When the individual cost-based rate has been established, the Department shall reconcile interim payments made for covered clinic services. The reconciliation will be based on two methods: 1) if the cost-based rate is higher than the interim rate, the Department shall pay the rate differential for each encounter claim paid at the interim rate, or 2) if the cost-based rate is lower than the interim rate, the provider shall refund to the Department the rate differential for each encounter claim paid at the interim rate, either by direct payment to the Department or as a credit applied against future encounter service claims.

After reconciliation to interim payments, the final rate determined for the start up period will be in effect for the period April 1, 1990 through June 30, 1991.

Payment shall be made at the interim encounter rate for clinics enrolled on or after January 1, 1991 for covered clinic services rendered between the date of enrollment and the certified date of provider receipt of the cost-based rate established by the Department. If the enrolled FQHC has not submitted the required audited fiscal information on the forms specified in this section within 90 days of the certified mail date of receipt of the forms, the Department shall suspend payment for covered clinic services until the required information is received by the Department, unless the enrolled FQHC has been in operation less than one year and has no audited cost history.

The Department will not process a claim for payment of clinic services rendered after June 30, 1990 that does not indicate all individual medical services delivered during the encounter by procedure code.

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iv. Upper Limits

The HCFA limit on the overall rate for costs which are allowable on HCFA Form 242 will be used as the Medicaid upper limit on these costs.

The following limits will apply:

A. Direct Care Productivity

FQHC must average 2.4 encounters per hour for all direct care staff.

B. Allowable Direct Cost Factor

Costs for physician assistants, nurse practitioners, nurse midwives, podiatrists and clinical psychologists are allowed as well as physician costs.

C. Screening Guideline for Non-Physician Health Care Staff

The maximum ratio of staff is four (4) full-time equivalent nonphysician health care staff for each full-time equivalent physician. Mid-level practitioners as listed in B. above are included in the same category as physicians.

D. Allowable Overhead

The Medicaid allowable overhead cost ceiling is 30 percent of the total allowable cost.

E. Overall Rate Ceiling

Medicaid will use the same ceiling as Medicare. Additional supplemental costs for pharmacy, patient transportation, medical case management, health education, nutritional counseling and dental services may exceed the ceiling. These costs will be capped by using the lower of: 1) the 75th percentile of statewide costs, or 2) the calculated supplemental medical and dental encounter rate.

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10/97 v. Adjustments for Medical Services Paid for by a Health Maintenance Organization, Pursuant to 42 U.S.C. §1396a.13..C.

The Department shall make payment adjustments to an FQHC if it provides care through a contractual arrangement with a Medicaid Managed Care Organization (MCO) and is reimbursed an amount, reported to the Department, that is greater than, or equal to, the minimum payment defined in 42 U.S.C. §1396a.13..C., but less than the percentage of reasonable and related costs also defined in 42 U.S.C. §1396a.13..C.. For each FQHC so eligible, a payment adjustment shall take into consideration the total payments made by the MCO to the FQHC (including all payments made on a service-by-service, encounter, or capitation basis) and any transitional payments made by the Department as defined in Attachment 4.19-B, page 1.E.. In the event that FQHC cost data related to MCO services are unavailable to the Department, an estimate of such costs may be used that takes into consideration other relevant data. Adjustments will be made only for Medicaid eligible services, as defined in this State Plan. All such services must be defined in a contract with an MCO. Such contracts must be made available to the Department.

=10/97 vi. Audits

All cost reports will be audited by the Department. The provider will be advised of any adjustments resulting from these audits.

10/97 vii. Appeals

Appeals of audit adjustments or rate determinations must be submitted in writing to the Department. All appeals submitted within 30 days of rate notification shall, if upheld, be made effective as of the beginning of the rate year. The effective date of all other upheld appeals shall be the first day of the month following the date the complete appeal was submitted. The Department of Public Aid shall rule on all appeals within 120 days of the date of the appeal except that, if the Department requires additional information from the facility, the period shall be extended until such time as the information is provided. Appeals for any rate year must be filed before the close of the rate year.

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3. RURAL HEALTH CLINICS: Depending on type of clinic in which services are provided. Hospital and encounter rate clinics: same as described in 1 and 2, respectively. For others and for non-Medicare covered services, fee-for-service subject to Department's established pricing screens.

4. PRESCRIBED DRUGS:

Effective July 1, 1995, pharmacies will be reimbursed for prescribed drugs on the following basis: the lower of their usual and customary charge to the general public, or

=7/95	a.	Single source legend products	-	standard package size AWP of NDC on claim, less 10%, plus a professional fee
=7/95	b.	Multiple source legend products not approved for generic interchange by the Illinois Department of Public Health	-	standard package size AWP of NDC on claim, less 12%, plus a professional fee
=7/95	c.	Multiple source legend products approved for generic interchange by the Illinois Department of Public Health, but not on the HCFA FUL list	-	lower of standard package size AWP of NDC on claim, less 12%, plus a professional fee OR generic reference AWP less 12% plus a professional fee
=7/95	d.	Multiple source legend products approved for generic interchange by the Illinois Department of Public Health, and on the HCFA FUL list	-	lower of standard package size AWP of NDC claim, less 12%, plus a professional fee OR generic reference AWP less 12% plus a professional fee OR HCFA FUL unit price plus a professional fee
	e.	Over-the-counter products	-	AWP times 1.5

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HCFA FUL limits will not be imposed on Schedule II, Controlled Substances, due to the Illinois Triplicate Prescription Program or products not approved for generic interchange by the Illinois Department of Public Health. When such generic products are approved for interchange by the Department of Public Health, MAC prices will be imposed in accordance with 4. above.

07/98 The use of some generic prices lower than the HCFA FUL, as described in 4 above, will ensure that aggregate reimbursement will not exceed the overall limits imposed by the HCFA FULs.

Drug prices are updated weekly utilizing a tape procured from First Data Bank of San Bruno, California.

5. OVER-THE-COUNTER DRUGS: Lesser of the usual and customary charge to the general public or the wholesale cost plus up to 50 percent.

6. OTHER LABORATORY AND X-RAY SERVICES: Lesser of the usual and customary charge to the general public or statewide maximums established by the Department not to exceed the upper limits specified in Federal regulations.

04/93 7. PHYSICIAN'S SERVICES: Reimbursement for physician services are at the physician's usual and customary charges, not to exceed the maximum established by the Department. Initially, maximum fee-for-service rates were established in 1978 when the Department reviewed the average charges for each of the allowable services. The Department agreed to set the statewide maximum amount at 70 percent of the average charge by physician. Annually the Department analyzes cost information and procedure code utilization of physician bills presented for Medicaid reimbursement of services rendered. The rate maximums are periodically adjusted based upon the above factors.

Providers statewide who meet the participation requirements for the Maternal and Child Health Program or qualify by the exception process receive enhanced reimbursement rates for services provided to pregnant women and children through age 20 who are participants in the MCH Program. The enhanced rates include:

- payment for performing a prenatal risk assessment ($15);
- payment for performing risk assessments on children ($15);
- increased reimbursement for deliveries ($400 additional);
- a $10 increase in the EPSDT screening rate; and
- an 8 percent increase in the reimbursement rate for office visits for children.

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8. DENTAL SERVICES: Reimbursement will be made for dental services by one of two methods depending on the recipient's category of service.

   a. For services provided recipients of AABD-MANG and AFDC-MANG and the Refugee/Expatriate Assistance - Lesser of the usual and customary charge to the general public or statewide maximums established by the Department not to exceed the upper limits specified in Federal regulations; or

   b. For services provided recipients of AABD-MAG and AFDC-MAG - Services will be administered through a prepaid dental plan. A flat monthly rate per enrolled recipient as established by the Department not to exceed the upper limits specified in Federal regulations will be paid to the dental health insuring organization.

9. EYE CARE SERVICES AND OPTICAL GOODS: Same as 6.

10. PODIATRIC SERVICES: Same as 6.

11. CHIROPRACTIC SERVICES: Same as 6.

12. HOME HEALTH CARE SERVICES: Lowest of individual home health agency's charge, approved Medicare rate or statewide flat rate established by the Department.